

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>012241</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/10/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>OUTREACH HEALTH CARE LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>7863 BROADWAY STE 126</b> <b>MERRILLVILLE, IN 46410</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 000}	<p>Initial Comments</p> <p>This revisit was for a state home health agency relicensure survey that was conducted April 2 - 3, 2013.</p> <p>Survey date: May 10, 2013</p> <p>Facility #: 012241</p> <p>Medicaid #: NA</p> <p>Surveyor: Ingrid Miller, MS, BSN, RN, Public Health Nurse Surveyor</p> <p>Census: 0 patients on active census since December 25, 2012 4 skilled unduplicated admissions for 2012</p> <p>During this survey, 1 deficiency was found to be corrected, 5 deficiencies were recited, 5 deficiencies remain uncorrected as it could not be determined they were in compliance due to having no patients, and 1 new deficiency was cited.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN May 16, 2013</p>	{N 000}		
{N 444}	<p>410 IAC 17-12-1(c)(1) Home health agency administration/management</p> <p>Rule 12 Sec. 1(c) An individual need not be a home health agency employee or be present full time at the home health agency in order to qualify as its administrator. The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (1) Organize and direct the home health agency's ongoing functions.</p>	{N 444}		

Indiana State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>012241</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/10/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>OUTREACH HEALTH CARE LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>7863 BROADWAY STE 126</b> <b>MERRILLVILLE, IN 46410</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{N 444}	<p>Continued From page 1</p> <p>This RULE is not met as evidenced by: Based on interview and review of agency documents, the administrator failed to ensure the agency was a functioning agency and documentation presented was accurate for 1 of 1 agency.</p> <p>The findings include</p> <p>1. On 5/10/13 at 11:15 AM, the administrator indicated there were no active patients at this time and that no marketing had occurred since the last survey as he was very busy with the plan of correction and correcting deficiencies cited on the survey conducted April 2 - 3, 2013.</p> <p>2. On 5/10/13 at 2:45 PM, the administrator indicated a patient referral had come from a physician in Illinois.</p> <p>A. An untitled referral document with a date of 5/10/13 and time of 1:32 PM included the name of physician in Illinois, the name of a patient with identifying information including an address, the Medicare identifying number, the patient's phone number, diagnoses, and stated, "Face-to-face to follow."</p> <p>B. On 5/13/13 at 9:50 AM, the referral patient listed on the document was called and indicated that the physician was the patient's primary physician, but the patient had not been referred to any home health agency including Outreach Health Care LLC.</p> <p>C. On 5/14/13 at 2:50 PM, an office staff member of the physician listed on the document</p>	{N 444}			

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>012241</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/10/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>OUTREACH HEALTH CARE LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>7863 BROADWAY STE 126</b> <b>MERRILLVILLE, IN 46410</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 444}	<p>Continued From page 2</p> <p>returned a previous call from the surveyor and indicated the physician had not referred the patient for home health care with Outreach Health Care LLC.</p> <p>3. An agency document titled "Home Health Toll free Hotline" with no effective date stated, "The purpose of the toll free hotline is to receive complaints or inquires about home health agencies that are Medicare certified and operate in Indiana." This agency is not Medicare certified in Indiana.</p> <p>4. An agency document titled "Outreach Health Care, Inc. Services provided" with no effective date stated, "This is to inform you of all our billing rates [rates for all services presented] ... these are the rates that Medicare, public aid, and/or commercial insurance will be charged." This agency is not Medicare certified in Indiana.</p> <p>6. An agency document titled "Outreach Health Care, Inc. Client's rights and responsibilities" states, "As a client you have the right to ... Be informed orally and in writing in advance of coming under the care of the agency of ... all items and service furnished by or under all arrangements with the agency for which payment will be expected under Medicare / Medicaid or any other Federal program of which the agency is reasonably aware ... any charges for items and services not covered by Medicare .... As a client you have the responsibility ... select a provider of care in concert with the provision of the Medicare freedom of Choice requirement." This agency is not Medicare or Medicaid certified in Indiana.</p> <p>7. The agency document titled "Home Health agency outcome and assessment information [OASIS] statement of patient privacy rights" with</p>	{N 444}		

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>012241</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/10/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>OUTREACH HEALTH CARE LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>7863 BROADWAY STE 126</b> <b>MERRILLVILLE, IN 46410</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 444}	Continued From page 3  no effective date stated, "As a home health patient you have the privacy rights listed below ... You have the right to know why we need to ask you questions. We are required by law to collect health information to make sure 1) you get quality health care and 2) payment for Medicare and Medicaid patients is correct ... if you are not satisfied with our response, you can ask the Centers for Medicare and Medicaid services, the federal Medicare and medicaid agency, to correct your information ... this is a Medicare and Medicaid approved notice." This agency is not Medicare or Medicaid certified in Indiana.  8. The agency's admission packet included the Medicare Hot Line number as 1- 800 - 227 - 6334. The agency is not Medicare certified in Indiana.  9. The agency policy titled "Description of services" with an effective date of 6/23/09 stated, "Who pays? Medicare, Medical, and commercial services [for qualified clients] over home health services." This agency is not Medicare certified in Indiana.  10. On 5/10/13 at 3:05 PM, the administrator indicated the documents in findings #3 - #9 were inaccurate since this agency is not certified by Medicare."	{N 444}		
{N 447}	410 IAC 17-12-1(c)(4) Home health agency administration/management  Rule 12 Sec. 1(c)(4) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (4) Ensure the accuracy of public information	{N 447}		

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>012241</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/10/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>OUTREACH HEALTH CARE LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>7863 BROADWAY STE 126</b> <b>MERRILLVILLE, IN 46410</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{N 447}	Continued From page 4  materials and activities.  This RULE is not met as evidenced by: Based on document review and interview, the administrator failed to ensure the agency had an accurate public information brochure for 1 of 1 agency with the potential to affect all future patients and their medical providers.  Findings include  1. The agency was unable to provide a new public information brochure with accurate information related to payer sources and agency hours.  2. On 5/10/13 at 3:05 PM, the administrator indicated the alternate administrator had sent him the new public information brochure by email, but he was unable to find it.	{N 447}			
{N 449}	410 IAC 17-12-1(c)(6) Home health agency administration/management  Rule 12 Sec. 1(c)(6) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (6) Ensure that the home health agency meets all rules and regulations for licensure.  This RULE is not met as evidenced by: Based on clinical record review, administrative document review, interview, and policy review, the administrator failed to ensure the agency met all the requirements for licensure.	{N 449}			

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>012241</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/10/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>OUTREACH HEALTH CARE LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>7863 BROADWAY STE 126</b> <b>MERRILLVILLE, IN 46410</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{N 449}	Continued From page 5  The findings include  1. The administrator failed to ensure the agency was a functioning agency and documentation presented was accurate (See N 444).  2. The administrator failed to ensure the agency had a public information brochure (See N 447) .  3. The administrator failed to ensure the agency had an ongoing quality assurance program that objectively and systematically monitored and evaluated the quality and appropriateness of patient care, resolved identified problems, and improved patient care (See N 456).  4. The administrator failed to develop, implement, maintain, and evaluate a quality assurance program that uses objective measures and reflected the complexity of the organization and services provided and in which there was a provision for actions that resulted in improvement in performance (See N 472).  4. The administrator failed to ensure referral documents were accurate (See N 610).  5. The administrator failed to ensure the agency was in compliance with previously cited tags. On May 10, 2013, there were no active patients at the agency, so it could not be determined if the previously cited deficiencies had been corrected (See N 486, N 522, N 524, N 529, and N 537).	{N 449}			
N 456	410 IAC 17-12-1(e) Home health agency administration/management  Rule 12 Sec. 1(e) The administrator shall be	N 456			

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>012241</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/10/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>OUTREACH HEALTH CARE LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>7863 BROADWAY STE 126</b> <b>MERRILLVILLE, IN 46410</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 456	<p>Continued From page 6</p> <p>responsible for an ongoing quality assurance program designed to do the following:</p> <p>(1) Objectively and systematically monitor and evaluate the quality and appropriateness of patient care.</p> <p>(2) Resolve identified problems.</p> <p>(3) Improve patient care.</p> <p>This RULE is not met as evidenced by: Based on administrative documentation review, policy review, and interview, the administrator failed to ensure the agency had an ongoing quality assurance program that objectively and systematically monitored and evaluated the quality and appropriateness of patient care, resolved identified problems, and improved patient care for 1 of 1 agency with the potential to affect all future patients of the agency.</p> <p>Findings include</p> <p>1. A review of agency documents revealed a quality assessment and performance improvement tool and policy. Neither document included a system that would measure and analyze the data after the data was collected from the records and would objectively and systematically monitor the quality and appropriateness of patient care, resolve identified problems, and improve patient care.</p> <p>2. The agency policy titled "Outreach Health Care, LLC. Quality assessment and performance improvement (QAPI) policy" with an effective date of 4/17/13 stated, "Outreach Health Care, LLC. will conduct clinical and data entry audits as part of its Quality assessment and performance improvement activities to verify that collected OASIS data is consistent with reported OASIS data and that quality of care is rendered to the</p>	N 456		

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>012241</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/10/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>OUTREACH HEALTH CARE LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>7863 BROADWAY STE 126</b> <b>MERRILLVILLE, IN 46410</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 456	Continued From page 7  patient in accordance with Medicare and State guidelines. The agency's performance improvement activities identify and address any discrepancies in data collected and reported. Procedure: Auditor / reviewer will complete the QAPI tool and file it into the patients' clinical record. Clinical record compliance audit to be completed on a weekly basis to ensure that the quality assessment and performance is performed on all clients. Director of nursing / administrator to review outcomes of Audit form on a weekly basis."  3. The agency document titled "Quality Assessment and Performance Improvement Tool clinical record compliance audit" with an effective date of April 17, 2013, is a 5-page document that is for auditing an individual patient record including initial visit documentation, physician / verbal orders, skilled services visit notes, home health aide documentation / supervision, medication assessment changes, homebound status, patient rights, coordination of services, daily nursing visits, medical social services, therapy services, maintenance therapy, skilled nursing visits, observation and assessment, management of evaluation of care plan, documentation, and other compliance issues.  4. On May 10, 2013, at 2:40 PM, the administrator indicated the QAPI program consisted of a chart audit tool and no other quality assessment performance improvement had occurred.	N 456		
{N 472}	410 IAC 17-12-2(a) Q A and performance improvement  Rule 12 Sec. 2(a) The home health agency must	{N 472}		



Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>012241</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/10/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>OUTREACH HEALTH CARE LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>7863 BROADWAY STE 126</b> <b>MERRILLVILLE, IN 46410</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 472}	<p>Continued From page 8</p> <p>develop, implement, maintain, and evaluate a quality assessment and performance improvement program. The program must reflect the complexity of the home health organization and services (including those services provided directly or under arrangement). The home health agency must take actions that result in improvements in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement program must use objective measures.</p> <p>This RULE is not met as evidenced by: Based on administrative documentation review, policy review, and interview, the agency failed to develop, implement, maintain, and evaluate a quality assurance program that uses objective measures and reflected the complexity of the organization and services provided and in which there was a provision for actions that resulted in improvement in performance for 1 of 1 agency with the potential to affect all future patients of the agency.</p> <p>Findings include</p> <ol style="list-style-type: none"> <li>1. A review of agency documents revealed a quality assessment and performance improvement tool and policy. Neither document included a system that would measure and analyze the data after the data was collected from the records and reflected the complexity of the organization and services provided and in which there was a provision for actions that resulted in improvement.</li> <li>2. The agency policy titled "Outreach Health Care, LLC. Quality assessment and performance improvement (QAPI) policy" with an effective date</li> </ol>	{N 472}		

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>012241</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/10/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>OUTREACH HEALTH CARE LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>7863 BROADWAY STE 126</b> <b>MERRILLVILLE, IN 46410</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 472}	<p>Continued From page 9</p> <p>of 4/17/13 stated, "Outreach Health Care, LLC. will conduct clinical and data entry audits as part of its Quality assessment and performance improvement activities to verify that collected OASIS data is consistent with reported OASIS data and that quality of care is rendered to the patient in accordance with Medicare and State guidelines. The agency's performance improvement activities identify and address any discrepancies in data collected and reported. Procedure: Auditor / reviewer will complete the QAPI tool and file it into the patients' clinical record. Clinical record compliance audit to be completed on a weekly basis to ensure that the quality assessment and performance is performed on all clients. Director of nursing / administrator to review outcomes of Audit form on a weekly basis."</p> <p>3. The agency document titled "Quality Assessment and Performance Improvement Tool clinical record compliance audit" with an effective date of April 17, 2013, is a 5-page document that is for auditing an individual patient record including initial visit documentation, physician / verbal orders, skilled services visit notes, home health aide documentation / supervision, medication assessment changes, homebound status, patient rights, coordination of services, daily nursing visits, medical social services, therapy services, maintenance therapy, skilled nursing visits, observation and assessment, management of evaluation of care plan, documentation, and other compliance issues.</p> <p>4. On May 10, 2013, at 2:40 PM, the administrator indicated the QAPI program consisted of a chart audit tool and no other quality assessment performance improvement had occurred.</p>	{N 472}		

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>012241</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/10/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>OUTREACH HEALTH CARE LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>7863 BROADWAY STE 126</b> <b>MERRILLVILLE, IN 46410</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{N 486}	410 IAC 17-12-2(h) Q A and performance improvement  Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient.  This RULE is not met as evidenced by: On 5/10/13 at 11:15 AM, the administrator indicated there were no active patients at this agency. Therefore, it was unable to be determined if this deficiency had been corrected.	{N 486}			
{N 522}	410 IAC 17-13-1(a) Patient Care  Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows:  This RULE is not met as evidenced by: On 5/10/13 at 11:15 AM, the administrator indicated there were no active patients at this agency. Therefore, it was unable to be determined if this deficiency had been corrected.	{N 522}			
{N 524}	410 IAC 17-13-1(a)(1) Patient Care  Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status.	{N 524}			

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>012241</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/10/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>OUTREACH HEALTH CARE LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>7863 BROADWAY STE 126</b> <b>MERRILLVILLE, IN 46410</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 524}	Continued From page 11  (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items.  This RULE is not met as evidenced by: On 5/10/13 at 11:15 AM, the administrator indicated there were no active patients at this agency. Therefore, it was unable to be determined if this deficiency had been corrected.	{N 524}		
{N 529}	410 IAC 17-13-1(a)(2) Patient Care  Rule 13 Sec. 1(a)(2) A written summary report for each patient shall be sent to the: (A) physician; (B) dentist; (C) chiropractor; (D) optometrist or (E) podiatrist; at least every two (2) months.  This RULE is not met as evidenced by: On 5/10/13 at 11:15 AM, the administrator indicated there were no active patients at this agency. Therefore, it was unable to be	{N 529}		

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>012241</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/10/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>OUTREACH HEALTH CARE LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>7863 BROADWAY STE 126</b> <b>MERRILLVILLE, IN 46410</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 529}	Continued From page 12  determined if this deficiency had been corrected.	{N 529}		
{N 537}	410 IAC 17-14-1(a) Scope of Services  Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows:  This RULE is not met as evidenced by: On 5/10/13 at 11:15 AM, the administrator indicated there were no active patients at this agency. Therefore, it was unable to be determined if this deficiency had been corrected.	{N 537}		
N 610	410 IAC 17-15-1(a)(7) Clinical Records  Rule 15 Sec. 1. (a)(7) All entries must be legible, clear, complete, and appropriately authenticated and dated. Authentication must include signatures or a secured computer entry.  This REQUIREMENT is not met as evidenced by: Based on document review and interview, the agency failed to ensure referral documents were accurate for 1 of 1 referral document reviewed with the potential to affect all future agency documents.  Findings  1. On 5/10/13 at 2:45 PM, the administrator indicated a patient referral had come from a physician in Illinois.  2. An untitled referral document with a date of 5/10/13 and time of 1:32 PM included the name	N 610		

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>012241</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/10/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>OUTREACH HEALTH CARE LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>7863 BROADWAY STE 126</b> <b>MERRILLVILLE, IN 46410</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 610	<p>Continued From page 13</p> <p>of physician in Illinois, the name of a patient with identifying information including an address, the Medicare identifying number, the patient's phone number, diagnoses, and stated, "Face-to-face to follow."</p> <p>3. On 5/13/13 at 9:50 AM, the referral patient listed on the document was called and indicated that the physician was the patient's primary physician, but the patient had not been referred to any home health agency including Outreach Health Care LLC.</p> <p>4. On 5/14/13 at 2:50 PM, an office staff member of the physician listed on the document returned a previous call from the surveyor and indicated the physician had not referred the patient for home health care with Outreach Health Care LLC.</p>	N 610		